MANAGED CARE LIABILITY

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"Managed care" encompasses various mechanisms by which large systems administer the financing and delivery of health care. One such mechanism is the development of criteria to control the utilization of clinical services, such as diagnostic tests and procedures. Another is the imposition of restrictions on specialty referrals. The systems employing the mechanisms have been designated, among other things, health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Whatever the nomenclature, however, managed care is revamping many aspects of the traditional physician-patient relationship. Independent medical practitioners who once performed on a fee-for-service basis and managed their own practices as small businesses are being replaced by physicians operating within larger systems that control reimbursement. While practitioners previously made essential independent medical decisions, the current momentum is toward a system in which these decisions are subject to insurer review, with a goal of cost containment.[1] Civilian practitioners, particularly those in practice for 20 years or more, have witnessed a gradual evolution in health care delivery. Military physicians are now, or will soon be, experiencing similar changes under the Department of Defense Tricare Health Delivery System.

CHANGING THE HEALTH CARE LANDSCAPE

Civilian physician referral patterns have already been altered by managed care reimbursement arrangements. Whereas primary care physicians would previously refer fractures to a trusted local orthopedic surgeon, insurer restrictions often exclude such familiar specialists and instead mandate referrals to "participating" orthopedic surgeons with whom the primary care physician may have had little or no prior contact.

Diagnostic testing has also been affected. Not only do certain objective criteria often have to be met before reimbursement is approved, but the site of performance for approved tests may also be restricted to designated locations or laboratories. If radiographs are performed on site in a large outpatient setting, existing practice procedures which provide for review of all studies by a radiologist may be abandoned as a cost savings mechanism. Rather than the blanket review of all films by radiologists, primary care physicians may be responsible for a definitive diagnostic interpretation of more common studies with subsequent readings by radiologists reserved for highly specialized examinations.

Inpatient practices have also undergone revision, modifying further the parameters of the traditional physician-patient relationship. Admission for many diagnoses may only be approved if certain criteria regarding patients' signs and symptoms have been met. Other diagnoses limit the duration of hospitalization for which the provider will be reimbursed.

PHYSICIAN LIABILITY

There are changes in physician liability which have accompanied the managed care revolution. Preferred provider organizations, health maintenance organizations, and similar systems have altered the application of traditional liability theories. Some of these changes have already spawned litigation, and some have the potential to alter the legal landscape.

Many experts view the gatekeeper role as one that increases the liability exposure of primary care providers.[2] Few claims currently attempt to impose liability using the gatekeeper concept. The nation's largest medical liability carrier, the St. Paul Fire and Marine Insurance Company, has noted, however, an increase in "failure to diagnose" claims.[3] With the emphasis on reducing specialty referrals and limiting sophisticated diagnostic studies, one wonders if primary care providers' gatekeeping role will increase their liability for failure to diagnose serious conditions. Claims arising from care rendered in physicians' offices have also seen a sharp increase from 32.6 percent of reported claims in 1988 to more than 45 percent in 1992.[4] Again, this increase in office-based claims may be coupled with the current trend away from hospitalization and aggressive specialty evaluations and could represent a shifting of liability risks to the office-based generalist.

Managed care liability concerns, however, are not limited to the gatekeeper concept. Insurer authorization of hospital stays has provoked much discussion, and at least one leading case, *Wickline v. State of California*,[5] illustrates the potential legal risks of cost-containment systems. In that case, Lois Wickline experienced problems associated with her back and legs. Her family practitioner admitted her to the hospital for evaluation and consulted a specialist in peripheral vascular surgery. Following examination, the surgeon diagnosed her as suffering from arteriosclerosis obliterans with occlusion of the abdominal aorta just above the division of the iliac arteries.

Surgery was recommended, and because of the advanced arteriosclerosis, removal of a portion of the vessel and insertion of a synthetic graft was contemplated. The patient agreed to the surgery and was discharged home, pending authorization of the procedure from Medi-Cal, California's medical assistant program. The patient's family practitioner submitted a treatment authorization request and Medi-Cal approved the prospective surgery with 10 days of accompanying hospitalization.

The patient was admitted, and surgery was performed. The peripheral vascular surgeon was notified later on the same day of the surgery that Ms. Wickline was experiencing circulatory problems in her right leg. He suspected the development of a clot in the graft, and returned her to the operating room, where he reopened her right groin incision, identified and removed a clot, and resewed the graft. Her postoperative course was characterized by pain, spasm of lower extremity vessels, and hallucinations. Five days following the initial surgeries, Ms. Wickline was again returned to the operating room where a lumbar sympathectomy was performed to stop vasospasms and prevent clotting.

Her stormy postoperative course convinced the surgeon that an extension of her ten-day hospitalization was medically necessary. The main reason for extending hospitalization, in his mind, was to continue close observation, so that he could immediately address any additional postoperative complications that threatened limb preservation. The dangers of clotting and infection were viewed as significant enough to require continued inpatient management.

Since Ms. Wickline was a patient in California's medical assistant program, a request to Medi-Cal was prepared by the hospital's representative, in this case, a registered nurse, based upon information furnished by the surgeon. An additional eight days of hospitalization were requested. At Medi-Cal, the request was initially reviewed by their representative, another registered nurse, who felt that she could not approve the eight-day extension. She telephoned the Medi-Cal consultant, a board certified general surgeon, and presented the clinical circumstances triggering the eight-day extension request. A four-day extension, only half of that requested, was then approved by Medi-Cal. The Medi-Cal consultant later testified that, on the

information provided to him, it appeared that Ms. Wickline was not seriously ill and was progressing satisfactorily. The opinion of a peripheral vascular surgeon, however, was not solicited.

While the surgeon caring for Ms. Wickline disagreed with Medi-Cal's decision, he later testified that he thought they had the power to limit the duration of hospitalization. Accordingly, he discharged the patient four days earlier than he had planned, after explaining to her and her husband how the lower limbs should be cared for at home.

Soon after she returned home, Ms. Wickline experienced pain and a loss of color in the right leg. With the passage of several more days, the pain intensified and the leg appeared whitish. The patient initially did not contact her physician because she thought these changes were part of the normal recovery process. When her husband did call the physician, additional pain medication was prescribed. Finally, the pain became excruciating, and her husband again telephoned her physician, who recommended that she return to the hospital.

Nine days after her discharge from the hospital, she was readmitted. On examination, she was found to have a secondary infection of her right groin incision, a mottled right foot and a cool right leg. Physicians concluded that clotting had obstructed circulation to the leg. Because of the infection at the graft site, it was deemed inadvisable to surgically remove the clot because of the risk of septicemia. Instead, a regimen of anticoagulants, antibiotics, whirlpool baths, and bed rest was prescribed. These measures eventually proved unsuccessful, and ten days after hospital readmission, the patient's right leg was amputated.

The patient brought suit against Medi-Cal, arguing that their refusal to grant a full eight-day extension represented negligence in the form of a premature discharge and caused the loss of the limb. At trial, the peripheral vascular surgeon who initially operated on Ms. Wickline testified that, had the requested eight-day extension been granted by Medi-Cal, he would have been able to observe a color change and remove the clot from her graft, thereby saving the leg. Other experts disagreed, however, and stated that failure to continue hospitalization did not contribute to the loss of the limb.

A jury verdict for the plaintiff was returned. The State of California appealed, maintaining that the decision to discharge was made by a physician, not by Medi-Cal, and that if anyone is to blame for a premature hospital discharge, it is the attending physician. After hearing arguments on both sides, the court of appeals reversed the previous judgment for the plaintiff, holding that the State of California was not liable. In its opinion, the court pointed out that "Medi-Cal did not override the medical judgment of Wickline's treating physicians at the time of discharge."[6] Medi-Cal was merely implementing cost containment measures in a system of indigent health care but the decision to discharge was made by professionals. Pointedly, the court noted that the attending surgeon neither questioned nor appealed the limitation of the authorized hospital stay by Medi-Cal. Thus, Medi-Cal and the State of California ultimately escaped liability.

Legal commentators have noted that, although none of Ms. Wickline's physicians were named as defendants in this case, the appellate decision is significant for what it says about them and about physicians whose decisions conflict with managed care systems in the future.[7] In the court's view, physicians must continue to act reasonably and operate in the patient's best interests, regardless of economic pressures or cost containment system regulations. Moreover, the opinion strongly suggests that if medical necessity dictates a certain course of action, and the patient's needs conflict with a utilization review decision, the physician is

obligated to appeal such an administrative decision. In the court's view, physicians will still be held accountable for patient management decisions, despite contrary managed care policies.

A somewhat similar problem was presented in the more recent case of *Wilson v. Blue Cross of Southern California.*[8] There, the patient's two-month weight loss of 20 pounds and a diagnosis of drug dependency with major depression led to a psychiatric admission. The attending physician's treatment plan called for inpatient hospitalization for a period of three to four weeks. The patient's insurer, however, ruled that continued hospitalization beyond ten days was not medically necessary, and that any financial liability for future days of hospitalization would be borne by the patient himself. The physician did not appeal the insurer's decision but discharged the patient, who committed suicide shortly thereafter.

The patient's mother, as administrator of his estate, brought suit against the medical insurer and the utilization review firm that had refused to fund his continued hospitalization. She alleged that their action represented negligence and a tortious breach of contract which resulted in her son's death. Interestingly, as in the *Wickline* case, the patient's physician was not a named defendant.

At trial, a summary judgment was entered for the defendants, based upon the prior *Wickline* decision which was construed to hold that only physicians are legally accountable for discharge decisions. Upon appeal, the trial court's decision for the defendants was reversed, and the appellate court made clear that the lower court's decision was based on an overly broad interpretation of *Wickline.* In fact, the opinion stressed that insurers were not immune from such suits and that both physicians and insurers could be held liable, under the proper circumstances, for a negligent, premature hospital discharge. Perhaps most significantly, the opinion noted that physicians have a responsibility to appeal patient benefit denials, if such decisions conflict with medical necessity and the patient's best interests. The case was remanded for trial, but the parties subsequently entered into a settlement.

Both the *Wickline* and *Wilson* decisions illustrate the changing landscape of medicine in a managed care environment. Medical decisionmaking, formerly the sole province of physicians, now is shared with health insurers and the utilization review entities they may employ to control costs.[9] The cases also stand for a potential expansion of liability to these other medical decisionmakers. Future cases will more clearly define how these newer liability targets fit into the traditional malpractice scenario. For physicians, it is clear that sound clinical practice and aggressive advocacy of the patient's interest, when medical necessity dictates, will continue to be the best formula for avoiding liability.

A REFERRAL LIABILITY: A POTENTIAL CAUSE OF ACTION

Ultimately, the most dangerous liability risk in managed care systems may involve referrals. Commentators have noted the propensity of malpractice attorneys to seek "new theories of liability,"[10] and referral by a primary care provider to a participating specialist with whom he is unfamiliar may provide that opportunity.

Since speciality referral within managed care systems is often limited to a participating provider list, there may be instances where the referring physician is totally unfamiliar with the specialist. For instance, if a patient with a breast mass is referred to a general surgeon who practices at a distant hospital, the referring physician may have no personal knowledge of the surgeon's competence regarding breast disease. If this surgeon's failure to biopsy or some other patient management decision is alleged to be negligent, a

companion claim for negligent referral could conceivably be lodged against the referring physician. Evidence that the surgeon lacked board certification, previously mismanaged other breast mass patients at another hospital, or lacked competence in breast disease would only complicate the primary care provider's defense that he made a proper referral to a competent specialist.

Some have even suggested that referring physicians will face such great difficulty in ensuring referral to competent specialist within large, restrictive managed care systems that they should be insulated from liability through case law or state or federal legislation.[11] Without such legal protection, however, primary care physicians should take reasonable steps to avoid such liability through prudent inquiries. Development of new professional relationships with specialists, direct communication with those specialists and close patient follow-up remain valuable tools in ensuring the reasonableness of the referral.

The growth of managed care will continue to present both medical and legal challenges to practitioners. As time passes, case law will better define the legal responsibilities of all managed care participants, to include physicians, insurers, and utilization review companies. For now, there is no substitute for provider awareness that, despite practice changes, their primary legal and professional responsibilities remains with the patient, not the managed care organization.

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